PRINTED: 08/19/2008 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		E CONSTRUCTION	COMPLETED	
		09G179	B. WIN	1G	<u> </u>	08/	08/2008
NAME OF P	ROVIDER OR SUPPLIER			570	ET ADDRESS, CITY, STATE, ZIP CODI 11 13TH STREET, NW ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS	W	000			
W 114	August 6, 2008, the survey was initiated process. A random selected from a reswomen with menta disabilities. The fir based on observat and at two day proceeds, including 483.410(c)(4) CLIE Any individual who record must make  This STANDARD Based on interview failed to ensure enwere signed, for tw #1 and #2) include  The findings include  The findings include  1. Interview with C Professional (QMF the entrance confeadmitted to the factor of Client #1's habil 2008, at 5:06 PM rassessment dated review of the client assessment had not that completed the the survey, the factor psychological assessment assessment assessment sates as a second confeadmitted to the client assessment had not the survey, the factor psychological assessment assessment assessment assessment sates as a second confeadmitted to the client assessment had not the survey, the factor psychological assessment assessment assessment as a second confeadment of the client assessment as a confeadment of the client	makes an entry in a client's it legibly, date it, and sign it.  is not met as evidenced by: and record review, the facility tries in each client's record to of the three clients (Clients d in the sample.  Ide: Qualified Mental Retardation RP) on August 6, 2008, during trence revealed Client #1 was illity on May 24, 2008. Review itation record on August 7, revealed a psychological June 26, 2008. Continued its record revealed the ot been signed by the person assessment. At the time of illity failed to ensure Client #1's essment had been signed.	W	114	W 114 1. Psychology assessme was signed and dated. 2. Recreational assessme was signed and dated. In the future the QMRP will ensure that all assessments are reviewed for completion at the time of receipt and on the monthly QA of the clier records.	ent ed ne	8/22/08
		t #2's record on August 8,					(X6) DATE
LABORATOR	Y-DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(VO) DAIE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G179	B. WIN	IG		08/0	8/2008
METRO	ROVIDER OR SUPPLIER	,		570	ET ADDRESS, CITY, STATE, ZIP CODE 1 13TH STREET, NW ISHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTER DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 114	Therapy Assessme assessment was no completed the asse conducted with QM verified the facility's assessment was significant to the conducted with QM verified the facility's assessment was significant was significant to the conducted was significant to the conducted with the conducted was significant to the conducted with the conducted was significant to the conducted with the conducted was significant to the conducted with the con	revealed a Recreational nt dated May 4, 2007. The of signed by the individual that essment. Interview was RP on August 8, 2008 that failure to ensure the gned.	W 1				9/15/08
	This STANDARD is Based on observation review, the facility faservices met the ne (Client #1) included. The finding includes. Interview with the data August 7, 2008, at 1 #1 had a Individual approximately a mo As the Case Manag the Client #1's treat the client was doing since the client's trafacility.  At 10:35 PM, Client treatment area with staff member was of the client to participal Continued observation program staff, reveal	s not met as evidenced by: on, interview and record ailed to ensure that outside eds of one of the three clients in the sample.			W 120 The Day Program will in service the staff to use the multi modal communication system for the client as soon as the equipment is ordered and received. The S/L pathologist will also use this system at the client's residence.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IULTIPLE LDING	E CONSTRUCTION	COMPLETED	
		09G179	B. WI	1G		08/0	8/2008
NAME OF F	PROVIDER OR SUPPLIER			5701	ET ADDRESS, CITY, STATE, ZIP CODE 1 13TH STREET, NW .SHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG			OULD BE	(X5) COMPLETION DATE
W 148	communication probeing developed.  Review of the Client August 7, 2008 revelopment the day program darevealed that the intrecommended a coclient #1 that require communication system different times throutime for 3 consecutions.  Interview with the strevealed the new preceived in July 200 trained on how to intime of the survey, the evidence that the affixed has 420(c)(6) COM CLIENTS, PARENT.  The facility must no parents or guardian changes in the client limited to, serious ill or unauthorized abs.  This STANDARD is Based on interview failed to ensure famontified of significant.	gram was in the process of  t #1's habilitation record on ealed an Individual Service Meeting (ISPDM) was held at ted June 26, 2008. The plan terdisciplinary team mmunication program for red her to use a multi-modal tem to express herself at ughout the day 50% of the ive months.  taff member at 11:09 AM rogram for Client #1 was 18, but staff had not been replement the program. At the the facility failed to provide forementioned program had as outlined. MUNICATION WITH TS &  tify promptly the client's of any significant incidents, or it's condition including, but not ness, accident, death, abuse, tence.  In not met as evidenced by: and record review the facility ily members were promptly t incidents, for one of three cluded in the sample.	W 1		W 148 The QMRP, Residential Manager and the nurses have been in serviced on Incident Management Policy and Procedures. In the future the IMC and VP Operations will ensure that the Policy is followed and appropriate notifications are completed in a timely manner during the monthly incident review meetings.	e	8/21/08

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	ILDING	G	COMPLETED		
		09G179	B, WII	νG		08/0	08/2008
NAME OF P	ROVIDER OR SUPPLIER			57	EET ADDRESS, CITY, STATE, ZIP CODE 701 13TH STREET, NW /ASHINGTON, DC 20011	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 148	Interview with Qual Professional (QMF AM revealed Clien involved in her habthe facility's incide investigations on A revealed the facilit Client #2's sister wincidents:  - On July 15, 2007 complain of stomato the emergency discharged.  - On August 16, 20 experienced a seizover five minutes.' personnel was not	age 3  Ilified Mental Retardation RP) on August 6, 2008, at 9:36 It #2 had a sister that was  Illitation and care. Review of Interports and corresponding August 6, 2008, at 3:19 PM Interports and corresponding Interports and		148			
	reported that Clier program. When the was noted to indict was subsequently for chest x-ray. O was noted to have abrasions on her right side of her faction that was again to appeared to be drotte morning. The be "coarse" and start the client was taken to be the morning.	8, 2007, day program staff at #2 fell while leaving her day e client returned home, she ate that her chest was sore and taken to the emergency room n October 3, 2007, Client #2 bruises on her right palm, ight shoulder and chin, and the ce was slightly swollen. The aken to the hospital for x-rays.  6, staff noted that Client #2 bwsy and slept the majority of client's voice was also noted to the complained of feeling cold. en to the emergency room and a diagnosis of pneumonia.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL _DING	E CONSTRUCTION	COMPLETED	
		09G179	B. WIN	IG	<u> </u>	08/0	8/2008
METRO	ROVIDER OR SUPPLIER			570	ET ADDRESS, CITY, STATE, ZIP CODE 1 13TH STREET, NW ISHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 148	Continued From pa	ige 4	W 1	48			
	short of breath. The failed to verbally re-	8, Client #2 was noted to be e client was called by staff but spond. Client #2 was taken to m and was treated and me day.					
At the time of the survey, the facility failed provide evidence that indicated Client #2 involved family (sister) was made aware aforementioned incidents.  W 149 W 149 CLIENTS		nat indicated Client #2's ter) was made aware of the cidents.	<b>W</b> 1	49			
	mistreatment, neglect or abuse of the client.  Manager a		The QMRP, Resident Manager and the nurs	es	8/22/08		
	Based on interview failed to implement client's health and s (Client #5) residing	•	•		have been in serviced on Incident Management Policy and Procedures. In the future the IMC and VP Operations will ensure that the Policy is followed and appropriate notifications are		
·		ensure investigations were working days as required and			completed in a timely manner during the monthly incident revieweetings.		
	6, 2008, at 12:21 F involving Client #5 According to the re in a fight with a stat Qualified Mental Re continued review of	by's incident reports on August PM revealed an incident dated August 30, 2007. port, Client #5 alleged she was ff member. Interview with etardation (QMRP) and f the facility's incident reports at 12:23 PM revealed the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		09G179	B. WING _	·	08/0	08/2008	
NAME OF P	ROVIDER OR SUPPLIER		5'	EET ADDRESS, CITY, STATE, ZIP C 701 13TH STREET, NW VASHINGTON, DC 20011	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
W 149	Interview was cond August 6, 2008, at information regarding management syste incidents that were completed within fix the facility's incident August 6, 2008 at 4 statement and furtheld weekly meetin President were resignalized investigation At the time of the sprovide evidence the policy was implemed 483.420(d)(4) STAICLIENTS  The results of all into the administrator or to other officials within five working of the adfive working days of the finding include Review of the facility.	ident was investigated on 7 (twelve days after the ucted with the QMRP on 12:16 PM to ascertaining the facility's incident in. According to the QMRP, investigated should be use business days. Review of the transpersent policy on 1:02 PM verified the QMRP's increvealed that the provider growthere the QMRP and Vice ponsible for reviewing the ponture, the facility failed to that the Incident Management anted outlined. FTREATMENT OF vestigations must be reported for designated representative in accordance with State law days of the incident.  Is not met as evidenced by: and record review, the facility uired investigations were ministrator or designee within the incident, for one of the 15) that resided in the facility.	W 149	W 156 Refer to W 148, W	149		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIF	PLE CONSTRUCTION  G	COMPLETED	
		09G179	B. WI	NG		08/0	8/2008
METRO	ROVIDER OR SUPPLIER			57	EET ADDRESS, CITY, STATE, ZIP CODE 701 13TH STREET, NW /ASHINGTON, DC 20011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 231	involving Client #5 According to the re in a fight with a star  Interview with Qual (QMRP) and continincident reports on revealed the aforer investigated on Sel after the incident). facility failed to pro- administrator or de the investigation wi incident as required 483.440(c)(4)(iii) IN  The objectives of the must be expressed provide measurable  This STANDARD in Based on observative review, the facility find goals and objective terms, for one of the included in the same  The finding include  The facility failed to program objectives terms.  Observation of the administration on A revealed Client #2 in Review of the client	dated August 30, 2007. port, Client #5 alleged she was f member.  ified Mental Retardation nued review of the facility's August 6, 2008, at 12:23 PM nentioned incident was otember 11, 2007 (twelve days At the time of the survey, the vide evidence that the signee reviewed the results of thin five working days of the discontinuous program plan in behavioral terms that he individual program plan in behavioral terms that he indices of performance.  In the service of the survey, the vide evidence that the signee reviewed the results of the discontinuous program plan in behavioral terms that he indices of performance.  In the service of the survey of the service o		231	W 231 All self medication assessments have been revised. In the future th DON and RN Supervis will ensure that all self medication programs an written in measurable terms. See attached programs	ne sor	8/21/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G179	B. WING _		08/0	08/2008
NAME OF P	ROVIDER OR SUPPLIER	-	5	REET ADDRESS, CITY, STATE, ZIP CO 5701 13TH STREET, NW VASHINGTON, DC 20011	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I \$HOULD BE	(X5) COMPLETION DATE
W 249	Interview with the Land Qualified Ment (QMRP) on August aforementioned ob objective. The LPN the client's success was measured. At nurse failed to provide client's success with determined. The fa#2's self medication written in measural 483.440(d)(1) PRO As soon as the interproper formulated a client'each client must retreatment program interventions and sand frequency to subjectives identified plan.  This STANDARD is Based on observative review, the facility freceived continuous	gram objective:  Iteem by self administering  Icensed Practical Nurse (LPN) al Retardation Professional 8, 2008 verified that the jective was the client's current I was queried to ascertain how with the program objective the time of the survey, the ride evidence of how the the objective could be acility failed to ensure Client in program objective was ole terms. IGRAM IMPLEMENTATION  Indisciplinary team has so individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the doin the individual program  Is not met as evidenced by: ion, interview and record alled to ensure each client so active treatment services, for ents (Client #1) included in the	" W 249	W 249 refer to W 120		

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	A. BUILDING			COMPLETED	
		09G179	B. WIN	IG		08/0	8/2008	
NAME OF PI	ROVIDER OR SUPPLIER			5701	T ADDRESS, CITY, STATE, ZIP CODE 1 13TH STREET, NW SHINGTON, DC 20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 249	program communic implemented as red 483.460(k)(1) DRU	ensure Client #1's day ation program was commended. (See W120) G ADMINISTRATION g administration must assure dministered in compliance with	w a		W 260			
	Based on interview failed to ensure that administered in comorders, for one of sithe facility.  The finding includes Observation of the administration on A 4:51 PM revealed C 40 mg. Interview with the same evening, with the the same evening, with the same evening of the survey of the survey, the same evening of the same even	npliance with the physician's x clients (Client #5) residing in			W 368 The facility nurse has corrected the error and the medication will be administered in the evening as prescribed by the PCP. In the future the RN Supervisor will ensure such errors do not occur and that the quarterly QA will prevent this from happening again.  See attached POS.	•	8/21/08	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MI A. BUII	ULTIPLE CONSTRUCTION LDING	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED	
		09G179	B. WIN	IG	08/0	8/2008
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 5701 13TH STREET, NW WASHINGTON, DC 20011	DE	·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
W 368	Continued From pa with the physician's		W	368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(IXI) I NO VIDELOGOI I EIELOGEIX		A. BUILDIN		(X3) DATE SURVEY COMPLETED	
	HFD03-0185		B. WING _		08/08/2008	}
NAME OF PROVIDER OR SUPPLIER				STATE, ZIP CODE	-	
METRO HOMES			I STREET, TON, DC 2			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	LETE
2008, through Aug sample of three res residential population retardation and other the survey were bar	was conducted from ust 8, 2008. A rando sidents was selected on of six women with er disabilities. The fixed on observations, eview of records, includes	from a mental ndings of	R 000			
criminal history of the contract worker for in all jurisdictions we employee or contratesided within the scheck.  This Statute is not Based on interview GHMRP failed to enchecks disclosed the prospective employ previous seven (7) which the prospection worker had worked (7) years prior to the The finding includes Interview with the QProfessional (QMRI personnel records of that the GHMRP failed criminal background disclosed a seven years of contracts.	round check shall dishe prospective employee the previous seven (ithin which the prospect worker has worked even (7) years prior the met as evidenced by and record review, the criminal background from the contract worked the employee or contract worked the check.  Signalified Mental Retained the check were on file ear history of all the the employee resided the checks were on file ear history of all the the employee resided the checks the check the contract worked the checks were on file ear history of all the the employee resided	cclose the byee or 7) years, ective d or o the cound any r for the cons within act seven cation GHMRP's vealed ce that and	R 125	R 125 See attached criminal background checks. In the future, the QM Residential Coordinat and the HR Dept. will ensure that monthly a are completed to mak sure all employee file kept in a current statu	ors  udits  are	//08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:		A. BUILDI	TIPLE CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED	
ALABAT OF	IDOMBED OF CHOSH I	HFD03-0185	OTDEET AS		<u> </u>		8/2008	
	ROVIDER OR SUPPLIER			H STREET,	STATE, ZIP CODE		'	
METRO	HOMES	•	WASHING	GTON, DC 2	20011			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
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Health Regulation Administration STATE FORM

PRINTED: 08/19/2008 FORM APPROVED

NAME OF PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN		95	(X3) DATE SURVEY COMPLETED	
NAME OF PF		HFD03-0185		B. WING _		08/0	08/2008	
METRO H	ROVIDER OR SUPPLIER		5701 13TH	RESS, CITY, S I STREET, N TON, DC 20				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
1 000	INITIAL COMMEN	TS		I 000				
I 082	2008, through Auguinitiated using the frandom sample of from a residential presental retardation affindings of the surviobservations, interveday programs, and unusual incident repairs and the same and the	censure survey was conducted from August 6, 28, through August 8, 2008. The survey was ated using the fundamental survey process. A dom sample of three residents was selected in a residential population of six women with intal retardation and other disabilities. The lings of the survey were based on servations, interviews at the facility and at two programs, and a review of records, including isual incident reports.  33.10 BEDROOMS AND BATHROOMS  The bathroom that is used by residents shall be sipped with toilet tissue, a paper towel and cup benser, soap for hand washing, a mirror and			provided in the bathro In the future the QMI	Disposable cups were provided in the bathroom.  In the future the QMRP		
	This Statute is not Based on observati	met as evidenced by on and interview, the bathrooms were equi	facility		and the Residential Coordinator will ensuthat this does not occur again by completing a monthly environment QA.			
-	The finding includes	s: ` `						
i   1   1	interview with the Q Professional (QMRI the environmental ir floor bathroom utiliz	GHMRP's environme qualified Mental Retar P) on August 8, 2008 aspection, revealed t ted by the residents f er for its disposable o	dation during he first ailed to			·		
1 206	3509.6 PERSONNE	EL POLICIES		I 206				
a	annually thereafter, certification that a h performed and that	or to employment and shall provide a physi ealth inventory has b the employee's hea	cian 's een		·			
ealth Regulat	tion Administration	inan T	-lone	(Ka)	3SMMA. TITLE VP-0		(X6) DATE	
ABORATORY I	DIRECTOR'S OR PROVID	WAW J Er/Supplier represen	TATIVE'S SIGN	ATURE	-1411/1 VI-0	peratury	8/4/0	

FORM APPROVED STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING HFD03-0185 08/08/2008 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5701 13TH STREET. NW METRO HOMES** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1206 Continued From page 1 1206 would allow him or her to perform the required duties. 1206 8/21/08 See attached health certificates This Statute is not met as evidenced by: In the future, the OMRP, Based on interview and record review, the Residential Coordinators GHMRP failed to ensure that each employee. and the HR Dept. will prior to employment and annually thereafter. ensure that monthly audits provided evidence of a physician's certification are completed to make that documented a health inventory had been sure all employee files are performed and that the employee's health status kept in a current status. would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and House Manager (HM) and review of the personnel records on August 8. 2008, beginning at 2:22 PM revealed that the GHMRP failed to provide evidence that current health certificates were on file for six direct care staff and four consultants. 1274 3513.1(e) ADMINISTRATIVE RECORDS 1274 I 274 See attached signed 8/21/08 Each GHMRP shall maintain for each authorized contract for psychologist agency 's inspection, at any time, the following and psychiatrist. administrative records: In the future, the QMRP, Residential Coordinators (e) Signed agreements or contracts for and the HR Dept. will

Health Regulation Administration

professional services;

This Statute is not met as evidenced by:

Based on interview and record review, the Group

Home for the Mentally Retarded (GHMRP) failed to provide evidence of all signed agreements and/or contracts for professional services.

JS0C11

ensure that monthly audits are completed to make

sure all employee files are

kept in a current status.

						FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER  HFD03-0185		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING		(X3) DATE S COMPL	ETED
					08/0	8/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
METRO	HOMES			H STREËT, I STON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERÊNCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1 274	Continued From page 2			1274			
	Professional (QMR personnel records provide evidence o the pharmacist and	Qualified Mental Reta (P) and review of the on August 8, 2008 fa f a contract or agree I psychiatrist.	GHMRP's ailed to				
I 291	Each record shall be signed by each independent of the signed on the signed to each of the signed to each of the signed to each of the signed t	ne kept current, dated ividual who makes are met as evidenced by and record review, the neuron entries in each ere signed, for two of the table and #2) include	n entry.  r: he f the three	I 291	I 291 refer to W 114		
	Professional (QMR the entrance conferwas admitted to the Review of Resident August 7, 2008, at psychological asse Continued review of revealed the assess the person that continue of the surv	rualified Mental Retar (P) on August 6, 2008 rence revealed Resic e facility on May 24, 2 t #1's habilitation reco 5:06 PM revealed a ssment dated June 2 of the resident's recor sment had not been inpleted the assessment rey, the facility failed in hological assessment	3, during dent #1 2008. ord on 26, 2008. d signed by ent. At to ensure				

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		·					): 08/19/2008 APPROVED
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0185		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE S COMPL	
NAME OF F	PROVIDER OR SUPPLIER	111 200 0100	5701 13T	H STREET, I		, 00,0	10,2000
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l 291	completed the asse conducted with QM verified the facility's assessment was sign	ot signed by the indiversement. Interview was lRP on August 8, 200 and the failure to ensure the	vas 08 that	I 291			
1 374	GHMRP shall prom guardian, his or her	CIES  ces have been secur poly notify the reside next of kin if the res representative of the	nt 's ident has	I 374	·		

This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that after medical services were secured, prompt notification of unusual incidents was made to resident's next of kin, followed by written notice and documentation of the resident's status no later than forty-eight (48) hours after the incident, for one of the three residents (Resident #2) included in the sample.

sponsoring agency of the resident 's status as soon as possible, followed by written notice and

documentation no later than forty-eight (48) hours

The findings include:

after the incident.

Interview with Qualified Mental Retardation Professional (QMRP) on August 6, 2008, at 9:36 AM revealed Resident #2 had a sister that was involved in her habilitation and care. Review of the facility's incident reports and corresponding investigations on August 6, 2008, at 3:19 PM revealed the facility failed to provide evidence that Resident #2's sister was made aware of the following incidents:

Health Regulation Administration

I 374

refer to W 148

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HFD03-0185				(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		08/	08/2008			
NAME OF F	PROVIDER OR SUPPLIER		ļ		STATE, ZIP CODE		-	
METRO HOMES 5701 13TH WASHING			H STREET, TON, DC 2	NW 0011				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
1 374	<ul> <li>Continued From page 4</li> <li>On July 15, 2007, Resident #2 was noted to complain of stomach pain. The resident was taken to the emergency room for evaluation and was discharged.</li> <li>On August 16, 2007, staff reported that Resident #2 experienced a seizure and was "unconscious for over five minutes." Emergency medical personnel was notified and the resident was taken to the emergency room for evaluation and treatment.</li> <li>On September 28, 2007, day program staff reported that Resident #2 fell while leaving her day program. When the resident returned home, she was noted to indicate that her chest was sore and was subsequently taken to the emergency room for chest x-ray. On October 3, 2007, Resident #2 was noted to have bruises on her right palm, abrasions on her right shoulder and chin, and the right side of her face was slightly swollen. The resident was again taken to the hospital for x-rays.</li> </ul>			1 374				
-								
·	appeared to be drow the morning. The re to be "coarse" and s cold. The resident w	staff noted that Resi wsy and slept the ma esident's voice was a she complained of fe was taken to the emo itted with a diagnosis	ajority of also noted eling ergency		,			
	be short of breath. staff but failed to ve	3, Resident #2 was n The resident was ca rbally respond. Resi nergency room and v d on the same day.	lled by ident #2					
	At the time of the su	urvey, the facility faile	ed to					

Health Regulation Administration

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		URVEY ETED	
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1 374	Continued From page 5			I 374				
	provide evidence that indicated Resident #2's involved family (sister) was made aware of the aforementioned incidents.							
1 379	3519.10 EMERGE	NCIES		1 379				
	In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident 's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.				I 379 refer to W 148			
	Based on interview GHMRP failed to el Health (DOH), Hea immediately notification within 2 that substantially in health, for one of the #2) included in the	•	he nt of was ncidents ent's					
	The finding includes:							
	interview Qualified Professional (QMR beginning at 3:19 P	y's incident reports a Mental Retardation P) on August 6, 2008 M, revealed the follo reported as required:	3, wing					
	reported that Resid	, 2007, day program ent #2 fell while leav n the resident returne	ing her					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE S COMPL	
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				H STREET, GTON, DC 2			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
1379	She was noted to indicate that her chest was sore and that day was subsequently taken to the emergency room for chest x-ray. On October 3, 2007, Resident #2 was noted to have bruises on her right palm, abrasions on her right shoulder and chin, and the right side of her face was slightly swollen. The resident was again taken to the hospital for x-rays. The facility failed to provide evidence that the DOH was notified of the September 28, 2007 visit to the emergency room. According to the DOH's incident management system, the DOH was notified of the incident on October 3, 2007.  - On August 4, 2008, Resident #2 was noted to be short of breath. The resident was called by staff but failed to verbally respond. Resident #2 was taken to the emergency room and was treated and released on the same day. The						
l 437	was notified of the a required.  3521.7(g) HABILITA  The habilitation and GHMRP shall include be limited to, the following the limited to, the following the lephone, letter write utilization of communication of	aforementioned incidental forementioned incidental forementioned incidental forementioned incidental forementioned incidental foremention of residents de, when appropriate flowing areas:  (including language sage, signing, use of ting, and availability a unications media, such a specialized equipment as evidenced by and record review, the	ent as  IG  by the , but not  the and h as elevision, ent as	I 437	I 437 refer to W 120		

Health Regulation Administration

GHMRP failed to ensure each resident received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET AL			DRESS, CITY,	STATE, ZIP CODE	1 00/1	.0,2000	
				H STREET, STON, DC 2				
(X4) ID PRÉFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (X (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY)		
I 437	Continued From page 7			1437				
	continuous active treatment services, for one of the three residents (Resident #1) included in the sample.							
	The finding includes	s:						
	Interview with the day program Case Manager on August 7, 2008, at 10:30 AM revealed that Resident #1 had a Individual Support Plan (ISP) meeting approximately a month and half ago (June 2008). As the Case Manager escorted the surveyor to the Resident #1's treatment area, she indicated that the resident was doing better at the day program since the resident's transfer to the new residential facility.  At 10:35 PM, Resident #1 was observed in her treatment area with the day program staff. A staff member was observed verbally prompting the resident to participate in a balancing program. Continued observation and interview with that day program staff, revealed the resident was nonverbal. The staff member further revealed that a communication program was in the process of being developed.							
	Review of the Resid August 7, 2008 reve Plan Development M the day program dat revealed that the intercommended a cor Resident #1 that req multi-modal commu- herself at different ti- of the time for 3 con	ealed an Individual Se Meeting (ISPDM) was ted June 26, 2008. The erdisciplinary team mmunication program puired her to use a nication system to extend mes throughout the discutive months.	ervice s held at The plan m for xpress day 50%					
	Interview with the starevealed the new pro- received in July 2006	ogram for Resident#	#1 was					

Health Regulation Administration STATE FORM

PRINTED: 08/19/2008 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUMBER 1		R/CLIA MBER;	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		HFD03-0185		B. WING			08/2008
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
METRO	HOMES		5701 13T WASHING	H STREET, STON, DC 2	NW 20011		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	(X5) COMPLETE DATE	
I 437	Continued From pa	ige 8		1 437			
	trained on how to implement the program. At the time of the survey, the facility failed to provide evidence that the aforementioned program had been implemented as outlined. [See Federal Deficiency Report W120]						
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